DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC#2

PRINTED: 03/27/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. BUILDING _____ B. WING _____	03/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF JEFFERSON CITY	336 WEST OLD ANDREW JOHNSON HWY JEFFERSON CITY, TN 37760

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey was conducted 3/20/17-3/22/17, at Life Care Center of Jefferson City. An entrance conference was conducted with the Administrator and the Director of Nurses on 3/20/17 at 8:45 AM. An exit conference was provided for the Administrator, the Director of Nurses, and the Regional Vice President. Findings were shared and questions answered.	F 000	Life Care Center of Jefferson City is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the state of Tennessee Department of Health toward the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted March 20th – 22th 2017. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements.	05/03/2017 05/03/2017
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 157	**What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) Family of resident #128 was notified on 3/24/2017 per DON and ADON to inform of resident exiting building with another family on 10/03/16. FNP was notified on 03/24/2017 of resident #128 exiting building on 10/03/2016 with another family member. 2) Emergency PI meeting was conducted on 3/21/2017 with DON, ADON, ED and Medical Director in regards to elopement/wandering policy and procedures.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alan F. Miranda | TITLE: Executive Director | (X6) DATE: 04/05/17

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 157	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of an informal facility report, and interview, the facility failed to notify the physician and the family of a change in condition related to elopement for 1 resident (#128) of 29 residents reviewed. The findings included: Review of the facility policy Elopement Policy, revised 4/2009, revealed "...Definition of Elopement: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to	F 157	**How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 3) All residents that were scored at elopement/wandering risk were re-assessed with assessment updated, care directive updated, and care plan updated as necessary. All nursing notes were reviewed on residents that were considered elopement/wandering risk to ensure that no other issues were identified that residents had been out of building on 3/21/2017 by DON, ADON, MDS, and care plan coordinator. All elopement/wandering residents were re-assessed per activities and care plans updated as necessary. LPN #1 was educated one on one in regards to notification of Medical Director, and family with any unusual occurrence and documentation in medical record, education was done by DON on 3/24/2017 100% of licensed nurses were educated by 04/14/2017 on notification of Physician, and family with any unusual occurrences and documentation in medical record of notification. All new associates will have education during orientation per DON, ADON and or SDC.	05/03/2017

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F 157	Continued From page 2 do so...charge nurse documents...family and physician notification...reports findings and condition of the resident..." Medical record review revealed Resident #128 was admitted to the facility on 9/28/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Anemia, Pain, Insomnia, and Atrial Fibrillation. Medical record review of the Minimum Data Set (MDS) dated 10/4/16, revealed a Brief Interview of Mental Status (BIMS) of 4 [severe cognitive impairment], Delusions [1 to 3 days], Wandering [1 to 3 days], and Wandering Impact "yes" [indicating the wandering placed the resident at significant risk of getting to a potentially dangerous place]. Medical record review of Licensed Practical Nurse (LPN) #1's Progress Note, dated 10/3/16 at 6:47 PM, revealed "...Found by CNA walking outside dining room, looking at foliage. DON [Director of Nursing] notified. Q [every] 15 min [minute] checks initiated..." Medical record review of an informal facility report, dated 10/3/16, revealed Resident #128 exited the building, visitors "going on to their car" called the DON, and reported the resident outside "in front of the dining room." Continued review revealed Certified Nursing Assistant (CNA) #3 brought the resident back into the facility, the DON ordered 15 minutes checks "...for the next few days..." and instructed LPN #1 to notify the family and Family Nurse Practitioner. Further review revealed 15 minutes checks performed from 5:15 PM on 10/3/16 through 11:00 PM on 10/8/16.	F 157	**What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 4) Audit tool for incident management to be conducted for Medical Director and Family notification. DON and ADON will present results to PI committee weekly for four weeks and monthly for two months. **How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 5) a) Director of nursing / Assistant director of nursing will present results of audits to the Performance Improvement Committee b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	05/03/2017

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F 157	Continued From page 3 Medical record review of Resident #128's Physician Orders revealed no orders for Resident #128 for 10/3/16 or 10/4/16. Continued review revealed no documentation of the elopement in the Physician's progress notes, the Social Service Director (SSD) notes, or the Care Plan Meeting notes, dated 10/14/16. Medical record review revealed no nursing documentation of the physician, physician extender, or family being notified of the elopement. Interview with LPN #1 on 3/21/17 at 3:50 PM, at the 200 Hall nursing station, confirmed she received a phone call on the evening of 10/3/16 from a CNA informing her Resident #128 was found outside the dining room, on the sidewalk at the front of the building, and she had been brought back into the facility. Further interview revealed LPN #1 telephoned the DON who instructed her to do 15 minute checks. Continued interview confirmed she did not notify the physician or the resident's family, "I think I put it on the Nurse Practitioner's log." Interview with the SSD on 3/21/17 at 5:35 PM, in the conference room confirmed she saw Resident #128 outside the building, walking by the dining room window, but did not document the event or notify the family. Interview with the Administrator and the DON on 3/22/17 at 6:25 PM, in the conference room, confirmed the facility failed to notify the physician and the family of Resident #128's elopement.	F 157		05/03/2017
F 225	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT	F 225		

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F 225 SS=D	Continued From page 4 ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 225	**What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) Resident #128 was re-assessed on elopement risk on 3/21/2017 by MDS nurse. DON updated resident #128 care directive to reflect wandering/elopement risk on 3/21/2017. 2) Meaningful and diversional activities plan was updated under the care plan for resident #128 on 03/22/2017 by Activities Director. 3) Executive Director placed signs on all entrance/exit doors for visitors to be aware that we do have wandering residents. **How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 4) 100% of elopement/wandering residents were re-assessed by MDS nurse and care plan coordinator nurse on 03/21/2017 and updated elopement books as necessary. 5) 100% of residents that are elopement/wandering risk had Occupational Therapy activity analysis completed by Occupational Therapist on 03/24/2017.	05/03/2017

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F 225	Continued From page 5 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of an informal facility report, and interview, the facility failed to report and investigate an allegation of elopement for 1 resident (#128) of 1 resident reviewed for elopement. The findings included: Review of the facility policy.Elopement Policy revised 4/2009 revealed "Definition of Elopement: Elopement occurs when a resident leaves the premises or a safe area without authorization	F 225	6) Activities Director updated 100% of resident's with elopement/wandering risk care plans on 03/22/2017. 7) Executive Director sent notification letters on 03/24/2017 to all families in regards to the elopement/wandering population in facility. 8) All department heads in-serviced on 03/21/2017 in regards to notifying ED and DON about unusual occurrences. 9) DON modified clinical meeting sheet on 03/28/2017 to include elopement/wandering topics to be discussed daily per IDT team. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 10) 100% of associates were in-serviced by 04/14/2017 on Elopement/Wandering policy and procedures by SDC. All new associates will be educated on elopement/wandering policy and procedures during orientation by DON, ADON and or SDC. 11) Weekly audit form to be conducted with weekly behavior management meeting by DON and ADON; if any new resident at risk for elopement should be identified the behavior management team will place the resident in elopement/wandering books. **How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 12) a) Director of nursing / assistant director of nursing will present findings to the Performance Improvement Committee.	05/03/2017

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F 225	Continued From page 6 (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so". Continued review revealed the inclusion of a decision making tree for reporting elopement "...if the staff were not aware of the resident leaving the facility, the facility is to conduct an investigation and report if neglect may have occurred..." Medical record review revealed Resident #128 was admitted to the facility on 9/28/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Anemia, Pain, Insomnia, and Atrial Fibrillation. Medical record review of the Progress Notes dated 10/3/16 at 6:47 PM, revealed "...Found by CNA walking outside dining room, looking at foliage. DON [Director of Nursing] notified. Q [every] 15 min [minute] checks initiated. No c/o [complaints] at this time...will continue to monitor..." Medical record review of the informal facility report, dated 10/3/16, revealed Resident #128 had exited the building with a visitor who called the DON to report the resident was (outside) in front of the dining room. Medical record review of the admission Minimum Data Set (MDS) dated 10/4/16 revealed a Brief Interview of Mental Status (BIMS) of 4 [severe cognitive impairment], Delusions [1 to 3 days], Wandering [1 to 3 days], and Wandering Impact "yes" [indicating the wandering placed the resident at significant risk of getting to a potentially dangerous place]. Interview with the Social Service Director (SSD),	F 225	b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	05/03/2017

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F 225	Continued From page 7 on 3/21/17 at 2:45 PM, in the SSD office revealed she was responsible for entering the MDS information for BIMS and behaviors, including delusions and wandering. Further interview revealed "...she would literally wander the entire building and attempt to follow the visitors out the door...in the fall...at dinnertime...she [Resident #128] walked out the door...I saw her, I was sitting in the dining room, and could see her out the window...CNA's [Certified Nursing Assistants] ran after her...the CNA's got her back in..." Interview with the Administrator on 3/21/17 at 6:18 PM, in the conference room, confirmed he was not aware Resident #128 eloped from the facility without staff supervision. Interview continued and confirmed the facility failed to follow their policy to create an incident report, investigate the elopement, and report the elopement to the state.	F 225		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323	**What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) Resident #128 was re-assessed on elopement risk on 3/21/2017 by MDS nurse. DON updated resident #128 care directive to reflect wandering/elopement risk on 3/21/2017. 2) Meaningful and diversional activities plan was updated under the care plan for resident #128 on 03/22/2017 by Activities Director. 3) Executive Director placed signs on all entrance/exit doors for visitors to be aware that we do have wandering residents.	05/03/2017

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F 323	Continued From page 8 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility records, and interview, the facility failed to conduct an investigation of a resident elopement, thereby failing to identify a root cause and any contributing factors for the elopement, for 1 resident (#128) of 1 resident reviewed for wandering. The findings included: Review of the facility policy Elopement Policy, revised 4/2009, revealed "...Definition of Elopement: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so..." Medical record review revealed Resident #128 was admitted to the facility on 9/28/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Anemia, Pain, Insomnia, and Atrial Fibrillation. Medical record review of the Minimum Data Set	F 323	**How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 4) 100% of elopement/wandering residents were re-assessed by MDS nurse and care plan coordinator nurse on 03/21/2017 and updated elopement books as necessary. 5) 100% of residents that are elopement/wandering risk had Occupational Therapy activity analysis completed by Occupational Therapist on 03/24/2017. 6) Activities Director updated 100% of resident's with elopement/wandering risk care plans on 03/22/2017. 7) Executive Director sent notification letters on 03/24/2017 to all families in regards to the elopement/wandering population in facility. 8) All department heads in-serviced on 03/21/2017 in regards to notifying ED and DON about unusual occurrences. 9) DON modified clinical meeting sheet on 03/28/2017 to include elopement/wandering topics to be discussed daily per IDT team.	05/03/2017

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F 323	Continued From page 9 (MDS), dated 10/4/16, revealed a Brief Interview of Mental Status (BIMS) of 4 [severe cognitive impairment], Delusions [1 to 3 days], Wandering [1 to 3 days], and Wandering Impact "yes" [indicating the wandering placed the resident at significant risk of getting to a potentially dangerous place]. Medical record review of Resident #128's initial Risk of Elopement/Wandering Review, dated 9/28/16, revealed "...*per report, *possibly exit seeking behavior." Further review revealed "...staff notified to keep close watch on resident's whereabouts..." Medical record review of Resident #128 Interim Care Plan, dated 9/28/16, revealed "Elopement risk: Wandering and/or exit seeking behaviors..." Medical record review of a Progress Note, dated 10/3/16 at 6:47 PM, revealed "...Found by CNA walking outside dining room, looking at foliage. DON [Director of Nursing] notified. Q [every] 15 min [minute] checks initiated. No c/o [complaints] at this time...will continue to monitor..." Medical record review of Resident #128's Physician Orders revealed no orders for 10/3/16 or 10/4/16. Continued review revealed no documentation of the elopement in the Physician's progress notes, the Social Service Director (SSD) notes, or the Care Plan Meeting notes, dated 10/14/16. Record review of the Daily Stand up Meeting sign-in sheet, dated 10/4/16, revealed the signatures of the Administrator, the Director of Nursing (DON), the Social Service Director	F 323	**What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 10) 100% of associates were in-serviced by 4/14/2017 on Elopement/Wandering policy and procedures by SDC. All new associates will be educated on elopement/wandering policy and procedures during orientation by DON, ADON and or SDC. 11) Weekly audit form to be conducted with weekly behavior management meeting by DON and ADON; if any new resident at risk for elopement should be identified the behavior management team will place the resident in elopement/wandering books. **How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 12) a) Director of nursing / assistant director of nursing will present findings to the Performance Improvement Committee.	05/03/2017

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	445275	A. BUILDING _____ B. WING _____	03/22/2017

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F 323	Continued From page 10 (SSD), MDS Coordinator, and the Housekeeper/Laundry Supervisor. Interview with the SSD, on 3/21/17 at 2:45 PM and at 5:25 PM, in the SSD office revealed "...she would literally wander the entire building and attempt to follow the visitors out the door...in the fall...at dinnertime...she [Resident #128] walked out the door...I saw her, I was sitting in the dining room and could see her out the window...CNA's [Certified Nursing Assistants] ran after her...the CNA's got her back in..." Interview with LPN #1 on 3/21/17 at 3:50 PM, at the 200 Hall nursing station, confirmed she received a phone call on the evening of 10/3/16 from a CNA informing her Resident #128 was found outside the dining room, on the sidewalk at the front of the building, and had been returned to the facility. Further interview confirmed LPN #1 telephoned the DON who instructed her to do 15 minute checks. Continued interview confirmed "...I considered that a safety risk..." and confirmed she did not complete an incident report. Interview with CNA #2 on 3/22/17 at 1:05 PM, in the conference room, confirmed on 10/3/17, on evening shift, she was asked by CNA #1 to help locate Resident #128. Continued interview confirmed she walked by the dining room and saw Resident #128 "next to the bushes on the sidewalk." Interview revealed she and CNA #3 went outside and returned the resident to the facility. Further interview confirmed she was not asked any questions by the administration or asked to write a statement regarding the incident. Interview with CNA #3 on 3/22/17 at 1:20 PM, in the conference room, confirmed she observed	F 323	b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	05/03/2017

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F 323	Continued From page 11 Resident #128 outside the dining room windows. Continued interview confirmed she was not asked any questions by the administration or asked to write a statement regarding the incident. Interview with the Administrator and the DON on 3/22/17 at 2:30 PM, in the conference room confirmed there was no discussion on 10/4/16, at the morning stand-up meeting attended by department heads, of the elopement and the facility failed to investigate an elopement for a resident at risk for wandering and elopement from the facility.	F 323		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371	**What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) 100% of dietary associates, director of food services and nutrition, central supply and housekeeping were educated on 3/22/2017 by ED on proper storage practices and on food in storage areas policy. 2) 100% of expired feeding tube cans were identified and properly disposed of. **How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 3) All residents that require nutrition through a feeding tube have the potential to be affected by improper food in storage areas practices. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 4) Dietary will audit food storage areas for four weeks and monthly for two months.	05/03/2017

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F 371	Continued From page 12 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary conditions in 1 of 2 resident nourishment rooms. The findings included: Observation of the Unit 1 resident nourishment room, with the Certified Dietary Manager (CDM), on 3/23/17 at 9:57 AM, revealed twenty-three 8 ounce (oz.) cans of Jevity 1.2 calorie (a tube feeding liquid) with expiration dates of 8/2016, and one 8 oz. can of Glucerna 1.2 calorie (a tube feeding liquid) with an expiration date of 2/2016, available for use by residents. The CDM confirmed at the time of discovery, the 23 cans of Jevity 1.2 and 1 can of Glucerna 1.2 were expired and should have been discarded.	F 371	**How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 5) a) Food services director will present results of audits to the Performance Improvement Committee b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services. Director of Social Services, Business office manager. Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441	**What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) 100% of shower teams were educated on 3/20/2017 by DON/ADON on proper cleaning and disinfection of non-critical patient care equipment and on dignity policy. 2) 100% of Charge nurses and CNA's were educated by DON/ADON on proper cleaning and disinfection of non-critical patient care equipment and on dignity policy by 04/14/2017.	05/03/2017

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F 441	Continued From page 13 communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 441	**How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 3) All residents have the potential to be affected by improper cleaning and disinfection of non-critical patient care. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 4) Unit managers will audit the cleaning of shower chairs between residents' showers weeklyfor four weeks and monthly for 2 months. **How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 5) a) Director of nursing / Assistant director of nursing will present results of audits to the Performance Improvement Committee b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the	05/03/2017

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F 441	Continued From page 14 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview the facility failed to properly clean and sanitize 1 of 2 shower chairs on Unit 2 available for use for 56 residents on Unit 2. The findings included: Review of the facility policy entitled Cleaning and Disinfection of Non-Critical Patient Care Equipment, revised 4/1/15, revealed, "...patient care equipment is cleaned daily and before and after use..." Observation of Unit 2 on 3/20/17 at 9:05 AM, revealed 2 bariatric shower chairs in the hallway, outside the shower room. Continued observation revealed dried brown debris around the rim of the shower chair seat and under the lid of the shower chair. Interview with Registered Nurse (RN) #1 on	F 441	committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	05/03/2017

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F 441	Continued From page 15 3/20/17 at 9:12 AM, at the Unit 2 nurses station, revealed shower chairs were kept in the hallway during shower times, placed back into the shower room for storage, shower equipment was cleaned at the end of the day, and after every use. Continued interview and observation of the shower chair with RN #1 confirmed dried brown debris on the rim of the shower chair seat and under the lid of the shower chair. Further interview confirmed the facility's policy on cleaning and sanitizing equipment was not followed and the shower chair was available for resident use, allowing a risk for cross contamination.	F 441		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520	**What corrective action will be accomplished for those residents found to have been affected by the deficit practice:** 1) 100% of department heads were in-serviced on 03/21/2017 on notifying ED and DON of any unusual occurrences. 2) Emergency PI meeting was conducted on 3/21/2017 with DON, ADON, ED and Medical Director in regards to elopement /wandering policy and procedures.	05/03/2017

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F 520	Continued From page 16 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, a maintenance record review, review of an informal facility report, review of the Incident Tracking Report, observation and interview, the facility's Quality Assurance Committee failed to investigate and identify safety concerns related to an elopement of 1 resident (#128) of 1 resident reviewed for wandering behavior. The findings included: Review of the facility policy Elopement Policy, revised 4/2009, revealed "...Definition of Elopement: Elopement occurs when a resident leaves the premises or a safe area without authorization..." Continued review revealed a	F 520	**How you will identify other residents having the potential to be affected by the same deficit practice and what corrective action be taken:** 3) IDT consisting of DON, ADON, ED and Medical Director will add and discuss elopement/wandering policy and procedures to PI starting 03/21/2017 **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 4) All department heads in-serviced on 03/21/2017 in regards to notifying ED and DON about unusual occurrences. 5) 100% of associates were in-serviced by 4/14/2017 on Elopement/Wandering policy and procedures by SDC. All new associates will be educated on elopement/wandering policy and procedures during orientation by DON, ADON and or SDC. **How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** 6) a) ED, Director of nursing / Assistant director of nursing will present findings to the Performance Improvement Committee.	05/03/2017

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F 520	Continued From page 17 Decision Tree was included in the policy with an indication to "investigate" if staff were not aware a resident left the facility. Medical record review revealed Resident #128 was admitted to the facility on 9/28/16 with diagnoses including Unspecified Dementia with Behavioral Disturbance, Anemia, Pain, Insomnia, and Atrial Fibrillation. Review of the maintenance records revealed the temporary public access/exit site had was established on 09/16/16, when the formal public access/exit was closed for use due to a motor vehicle accident. Review of an informal facility report, dated 10/3/16, revealed Resident #128 had exited the building from the temporary public exit, unaccompanied by staff, on 10/3/16. Continued review revealed visitors had called into the facility, "after going to their car" and observing Resident #128 on the front sidewalk of the facility. Review of the Incident Tracking report from 10/1/16-3/22/17, revealed the elopement on 10/3/16 was not included. Observation on 3/21/17 at 3:00 PM, of the public access/exit located off the main front hall of the facility, revealed a smaller hall which led to the front foyer of the facility. Continued observation revealed to the left of the small hall there was a beauty shop, to the right there was a conference room, and passage through double doors to the front foyer area that required pushing in on a bar across one of the doors to open. Observation revealed the door then automatically closed between uses. Continued observation revealed,	F 520	b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information Management, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business office manager, Activities Director and Staff Development Coordinator will review the results/ If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	05/03/2017

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F 520	Continued From page 18 directly in front of the double doors, the social services office, to the left the admissions office, and to the far right a door to administrative offices. Observation continued and revealed a slight right turn and ten steps led to double doors wired to a security system requiring a code to exit, followed by a second set of doors. Observation of the exit door, previously used as the temporary public access/exit, revealed it was accessed through 1 door, at the end of the long, front hallway. Continued observation revealed Resident #128's room was on the 200 Hall, the adjoining hall closest to the temporary exit. Interview with the maintenance director on 3/21/17 at 4:15 PM, in the conference room, revealed he was not sure of the exact date in November 2016 when the use of the front public access/exit resumed. Interview confirmed the side exit door, beyond the 200 Hall, was the temporary public access/exit from 9/16/16 through "sometime up in November." Interview with the Administrator on 3/22/17 at 2:40 p.m., in the conference room, verified the facility had admitted Resident #128 during the period of time when the temporary public access/exit was in use. Interview continued and confirmed the elopement was not recorded on an incident report, although required by the Decision Tree included in the facility's policy. Continued interview confirmed the Administrator did not know the incident had occurred, an investigation wasn't done, and therefore the Quality Assurance Committee failed to identify safety concerns related to the temporary exit or any other possible contributing factors related to the elopement.	F 520		05/03/2017